SCOTTISH HOME AND HEALTH DEPARTMENT

General Practitioners in the Hospital Service

HMSO 26p net

SCOTTISH HOME AND HEALTH DEPARTMENT

General Practitioners in the Hospital Service

Joint Working Party
on the Integration of Medical Work

Report of a Sub-group on General Practitioners in the Hospital Service

EDINBURGH
HER MAJESTY'S STATIONERY OFFICE 1973

This Report, prepared by a working party of doctors set up by the Secretary of State for Scotland, is published as a basis for further study of the questions with which it deals. The medical profession, the health authorities and the Government are not in any way committed by its recommendations.

SBN 11 490892 3

Preface

When the Joint Working Party was appointed by the Secretary of State for Scotland in December 1969 its first task in anticipation of re-organisation of the health service was to produce an analysis of the opportunities which would arise from the integration of medical work for improving our arrangements for medical care. The result was the publication in 1971 of the report entitled *Doctors in an Integrated Health Service* which has stimulated continuing discussion on important issues which affect everyone concerned with health care in Scotland.

The report indicated that further studies would be necessary and for this purpose, in November 1971, the Joint Working Party appointed four Sub-groups, each comprising some members of the Joint Working Party with additional members co-opted to reflect different professional backgrounds and experience. It was the remit of one of those Sub-groups to study and make recommendations on General Practitioners in the Hospital Service. This their report is now published as one of a series of studies by the Joint Working Party arising from its first report.

JOHN BROTHERSTON
Chief Medical Officer

Membership of Joint Working Party on Integration of Medical Work

Sir John Brotherston, MA, MD, DPH, DR PH, FRCP(EDIN), FRCP(GLAS), FRSE (*Chairman*)
A. Allison, Esq, B SC, MD, FRCP(GLAS), FRCP(LOND)
Professor T. Anderson, CBE, MD, FRCP(EDIN), FRCP(GLAS)
Professor Sir John Bruce, CBE, TD, MB, CH B, FRCS(EDIN), FRSE
Professor J. Crooks, MD, FRCP(LOND), FRCP(EDIN), FRCP(GLAS)
Professor A. R. Currie, MB, CH B, FRCP(EDIN), FRCP(GLAS), FRCP(LOND), FRC PATH, FRSE
Professor A. S. Duncan, DSC, MB, CH B, FRCS(EDIN), FRCP(EDIN), FRCOG
J. L. Gilloran, Esq, MB, CH B, DPH
N. G. C. Hendry, Esq, MB, CH B, FRCS(EDIN)
W. B. McN. Howie, Esq, MB, CH B, DCH, DPA, MFCM
I. M. Macgregor, Esq, MD, DPH, FRCP(GLAS)
J. Mackay, Esq, MB, CH B
P. A. P. Mackenzie, Esq, O ST J, JP, LRCP&S(EDIN), LRFPS(GLAS)
Professor A. K. M. Macrae, MB, CH B, FRCP(EDIN), FRCP(GLAS), FRC PSYCH, DIPL PSYCH
J. E. Miller, Esq, JP, LRCP, MRCGP
W. M. Patterson, Esq, MB, CH B, MRCGP
H. G. Robinson, Esq, MB, CH B, DPH
C. J. Swanson, Esq, OBE, MB, CH B
A. W. Wright, Esq, MD, FRCP(EDIN)
R. B. Wright, Esq, DSO, OBE, B SC, MB, CH M, FRCS(EDIN), FRCS(GLAS), FRCP(LOND)

Observers

F. D. Beddard, Esq, MB, BS, MRCP(EDIN)
S. J. Hadfield, Esq, MA, MB, B CHIR, MRCP(EDIN)

Assessors

Dame Muriel Powell, DBE, SRN, SCM
E. U. E. Elliott-Binns, Esq
J. Hogarth, Esq
W. P. Lawrie, Esq

Secretariat

D. M. Pendreigh, Esq, MB, CH B, DPH, FRCP(EDIN) (until November 1971)
D. W. A. McCreadie, Esq, LRCP(EDIN), LRCS(EDIN), LRFP&S(GLAS), MFCM, FHA (from November 1971)
G. R. Wilson, Esq

Membership of Sub Group

Professor J. Crooks, MD, FRCP(LOND), FRCP(EDIN), FRCP(GLAS) (*Chairman*)
A. G. Donald, Esq, MA, MB, CH B, MRCGP
A. H. Duncan, Esq, MB, CH B, DPH
J. Knox, Esq, MB, CH B, MRCP(LOND)
Professor K. G. Lowe, MD, FRCP(LOND), FRCP(EDIN), FRCP(GLAS)
Professor E. M. McGirr, B SC, MD, PRCP(GLAS), FRCP(LOND), FRCP(EDIN)
I. M. Macgregor, Esq, MD, DPH, FRCP(GLAS)
J. Mackay, Esq, MB, CH B
P. A. P. Mackenzie, Esq, O ST J, JP, LRCP&S(EDIN), LRFPS(GLAS)
T. C. K. Marr, Esq, BA, MB, B CHIR, MRCP(LOND)
J. B. Rae, Esq, TD, MB, CH B, DPM
A. G. Reid, Esq, MB, CH B, FRCGP
Professor I. M. Richardson, PH D, MD, DPH, FRCP(EDIN), MRCGP
G. B. Shaw, Esq, B SC, MB, CH B, FRCP(LOND), FRCP(EDIN), FRCP(GLAS)
F. I. Stewart, Esq, MB, CH B, MRCGP, DCH
J. D. Thomson, Esq, MB, CH B, FRCS(GLAS), FRCS(EDIN)

E. Errington, Esq
W. P. Lawrie, Esq
Mrs A. M. Mazzoni, RGN, SCM, ONC
K. M. Parry, Esq, MB, CH B, MRCP(EDIN), DCH
G. A. Scott, Esq, MB, CH B, DPH
D. W. A. McCreadie, Esq, LRCP, LRCS(EDIN), LRFPS(GLAS)

J. T. Baldwin, Esq, OBE, JP, MB, CH B, MRCGP

Contents

		page
	Preface	iii
	Membership of Joint Working Party	iv
	Membership of Sub-group	v
	Foreword	ix
Chapter		*paragraphs*
1	**General Practitioners in the Hospital Service**	1.1–1.8
2	**The Case for Integration of General Practitioners in the Hospital Service**	2.1–2.6
3	**General Practice in the Future**	3.1–3.5
4	**General Practitioners Beds**	4.1
	The General Practitioner Hospital Unit	4.2
	The General Practitioner Hospital	4.3
	General Practitioner Beds in Specialists Units	4.4
5	**The General Practitioner as a Member of the Specialist Team**	5.1–5.18
6	**Education and Training**	6.1–6.5
7	**Conclusions**	7.1–7.4.5
	Acknowledgment	

Foreword

This Sub-group was set up under the Chairmanship of Professor James Crooks by the Joint Working Party on 22 October 1971.

Our remit was to consider how the general practitioner could more effectively participate in the work of the hospital service in the light of the recommendations in the Report *Doctors in an Integrated Health Service*. That Report concluded *inter alia*

i 'General practice should remain the mainstay of the health care system. But it must be strengthened so that general practitioners are equipped in terms of both training and resources to undertake greater clinical responsibility. General practitioners should have better supported places of work with adequate diagnostic facilities readily available to them and they should increasingly have access to beds in which they might care for some of their own patients in hospital'. (Para 167)

ii 'As the scope of general practitioners' clinical responsibilities widens, specialists will be enabled to devote their energies and skills to the provision of the kind of services for which they alone are trained. At the same time there should develop greater working contact between specialists and general practitioners: specialists should become more directly involved in the provision of front line care, and general practitioners with the necessary training should be encouraged to work in specialist units in hospital'. (Para 168)

We met on nine occasions. Most of the members prepared papers which were fully discussed by the Sub-group and which formed the basis of the report.

Although we did not ask for formal evidence, several doctors outwith the group attended the meetings and took part in the discussions and to them we are greatly obliged.

Chapter 1 General Practitioners in the Hospital Service

Introduction

1.1 Our report aims at the creation of better facilities for the general practitioner to care for his patients by his more effective participation in hospital work in the conviction that this will be to the advantage of patients in providing them with an improved quality of clinical care, of the general practitioner in offering increased professional understanding and satisfaction and of the service in securing the optimum use of resources.

1.2 At the present time a large number of general practitioners hold hospital appointments. Out of a total of about 2625 principals in general practice in Scotland at 1 October 1971 some 614 or 23 per cent were engaged in some kind of hospital work. The usual arrangement is that groups of general practitioners contract to attend patients (usually their own) in general practitioner (cottage) hospitals (13·5 per cent) or that individual practitioners work in hospital on a sessional basis (12·6 per cent). The latter arrangement includes participation in a variety of disciplines such as medicine, psychiatry, geriatrics, anaesthetics. Some doctors hold appointments of both kinds.

1.3 Most of the doctors who provide medical services in general practitioner hospitals practise in rural areas; in urban areas participation is mainly in specialist units. Both arrangements provide a high level of satisfaction to the patients and doctors concerned. The advantages include convenience, educational opportunity resulting from contact with specialist staff, widening of professional interest, improved standards and continuity of care.

1.4 It is clear that the advantages which can result from general practitioner participation in hospital practice have not been fully achieved on a sufficient scale. We are satisfied that the time is opportune for a purposeful development of schemes which will enable general practitioners to play an important role in the hospital service.

1.5 It has been clear to us from the outset of our deliberations that the possibility of achieving greater participation by general practitioners in the work of the hospital and specialist service must be considered against the background of the forthcoming change in the administrative structure of the National Health Service and the opportunity this will offer for closer co-operation of doctors working in different clinical fields. While the ultimate objectives discussed in our report can only be achieved in

full by a process of evolution we believe that rapid progress can be made by the promotion of new and the expansion of existing vocational training schemes matched by a rapid increase in the number of opportunities for general practitioners to become involved in hospital work. Our report therefore seeks to define the kind of arrangements which will make it possible to speed up these developments; and we think it important that schemes of general practitioner involvement should be tried out and evaluated in a variety of different settings in order to demonstrate the full benefits to be derived from this kind of integration.

1.6 Although our proposals are likely to meet every shade of reaction from doctors both in and outside hospital we think that the pace at which they are implemented should take account of the expectations and requirements of the younger graduates as they emerge into practice and create demand and momentum, as well as the aspirations of the established practitioners.

1.7 If our recommendations are accepted they will involve a number of changes in clinical structure and manpower distribution in both general and hospital practice, in undergraduate and post-graduate education and in vocational training.

1.8 We acknowledge that our recommendations will only be justified if they lead to an improved quality of patient care; but as the rest of this report shows, we are satisfied that they will do so.

Chapter 2 **The case for Integration of General Practitioners in the Hospital Service**

2.1 The Joint Working Party Report *Doctors in an Integrated Health Service* discussed the problem of re-establishing the general practitioner in the hospital service after a long period in which these two branches of the service had become progressively isolated from each other. Two needs were recognised—first an arrangement whereby the general practitioners could admit some of their patients to hospital and continue to be responsible for their clinical care and, second, an arrangement which would provide increasing opportunities for general practitioners to take part in the work of hospital-based specialist units.

2.2 Re-integration of general practitioners into the hospital service tends to be regarded as mainly to the advantage of the doctors themselves. It is in fact the patients who should benefit most. Closer integration of general and specialist care with improved communication between doctors and between doctors and patients should result in a greater level of understanding and a more effective provision of medical care. The duration of incapacity resulting from illness could well be reduced and the patient's rehabilitation improved and accelerated.

2.3 As far as the use of hospital beds by general practitioners for their own patients' care is concerned experience has shown that arrangements of this kind are both practical and effective, as has been demonstrated by the contribution of many 'cottage' or 'general practitioner' hospitals to the medical care system, particularly in rural areas. In the different circumstances of urban areas the polarisation of hospital and general practitioner services has almost prohibited this kind of arrangement with a few outstanding exceptions.

2.4 The integration of family medicine and specialist medicine which will be achieved by general practitioner participation in a specialist unit will create new opportunities for research. Scientific expertise and facilities will become more readily available to workers in the community and better opportunities will be offered for the study of patients and their diseases in domestic surroundings.

2.5 The interaction of the general practitioner and specialist which is likely to occur in the environment thus created will provide an opportunity for the general practitioner to develop special aptitudes and skills and enable the specialist to be better informed of the results of his activities in terms of service to the community as a whole.

2.6 The continuing and intimate professional contact which must result from arrangements of this kind will be a powerful force in maintaining the highest level of medical knowledge and competence throughout the service. Further, such an arrangement is necessary if hospital specialists are to be relieved of the responsibility of providing day-to-day care for patients who could very well be looked after in whole or in part by their own family doctor. The specialists will benefit from the opportunity to concentrate their expertise and resources on the practice and development of their specialty. The general practitioners will benefit in terms of professional skill and satisfaction by using the technical resources of the hospital and the help of their specialist colleagues in handling the clinical problems of their patients at the primary care level. The hospital as a whole will benefit from the more direct contact with the general practitioners and through them the community it serves and, as we have already noted (para 2.2), the individual patient should benefit from improved medical care.

Chapter 3 **General Practice in the future**

3.1 Although our report is not primarily concerned with the work of the general practitioner outside the hospital, our proposals will be meaningless unless they are in keeping with the likely developments in this clinical field. As far as we are able to judge, the general medical (family doctor or primary medical care) service of the future is likely to have the following characteristics—namely it should be:

(i) a comprehensive and integrated clinical system capable of supporting a broad spectrum of preventive, diagnostic, therapeutic and rehabilitative activity in collaboration with other agencies which contribute to health care.

(ii) readily accessible to the community and able to provide continuity of medical care.

(iii) based mainly on health centres which could with advantage be functionally and even physically related to a hospital and which are large enough to attract the maximum professional and technical support.

(iv) staffed by family doctors who, in addition to having personal responsibility for the continuing care of their patients, will have access to hospital facilities in their own right and the opportunity to take part in the work of hospital-based specialist departments.

(v) supported by hospital specialists some of whom will spend part of their time in health centres co-operating with colleagues in the primary care service; by community medicine specialists; by teams of nurses working in health centres and in domiciliary practice; by a range of supporting staff including secretaries, physiotherapists, occupational therapists and others; and by social workers.

(vi) made up of teams of doctors and others which are significantly larger than those to which we have become accustomed, and so organised that the members of the team will have opportunities to maintain a high level of clinical competence by post-graduate study and to provide sufficient time for relaxation and leave.

(vii) able to create an environment in which the personal doctor can utilize the advantages of the team approach in the service of his patient. The goal of technical competence should not conflict with the personal identification of the doctor with his patient, which is one of the outstanding characteristics of general practice in this country.

3.2 The health centre programme is proceeding at such a pace that there is every expectation that the majority of general practitioners in Scotland will operate from such centres by the 1980's.

3.3 If general medical practice is to develop in this way it is incontrovertible that the changes which will take place in clinical organisation and responsibility will require to be accompanied by changes in the distribution of medical manpower. It would be unrealistic to assume that the family doctor could increase his range of work to include any significant amount of hospital-based activity without reducing the time available for family care. While some infusion of medical manpower into the primary medical care system might be necessary, and could be achieved by redistribution over the whole clinical field, significant support to general practice could be made by the participation of suitably trained nursing and ancillary staff.

3.4 If the general practitioner is to participate in the work of specialist units it is unlikely that this can be achieved without a significant commitment of his time. On the other hand we do not think that the general practitioner should find difficulty in looking after the relatively few of his own patients who require admission to a general practitioner hospital unit as envisaged in 4.2 and to the type of acute medical care which it is within his competence to provide.

3.5 While we have attempted in this section to predict the shape of general medical practice as we see it emerging in the future, we do not regard the more effective involvement of the family doctor in hospital work as necessarily being dependent on his participation in health centre or group practice.

Chapter 4 General Practitioner Beds

4.1 In this section we consider what opportunities might be created for general practitioners to admit and look after their own patients in hospital. The options suggested by the Joint Working Party—beds in separate general practitioner wards, beds in separate general practitioner hospitals or general practitioner beds in specialist units—have all been considered. It is our view that the first option will be most appropriate and acceptable to a large number of doctors and their patients in the urban situation. Since we believe that a significant proportion of patients at present admitted to hospital could be looked after by their family doctors in the hospital our proposals do not in the first instance envisage the provision of additional beds but a reallocation of existing beds.

4.2 The General Practitioner Hospital Unit—Beds in separate General Practitioner wards

(i) The general practitioner hospital unit—that is, a block of beds for which general practitioners have full clinical responsibility—should be an integral part of a larger acute hospital, making use of the supporting services and forming part of an integrated clinical system. We see these units as serving a large part of the acute medical needs of the local community. The general practitioners concerned in providing this service should be members of a divisional medical organisation based on the hospital in which they work. This type of unit would play an increasingly important role in bridging the gap between the primary medical care and the hospital services and we would expect that the integration of the work of medical staff over the whole range of ambulatory and hospital care services will be matched by a similar integration of nursing and other services.

(ii) We have given a good deal of thought to the operational specification for these general practitioner hospital units and have concluded that precise definition is both difficult and unnecessary because the work pattern will vary with local circumstances. It can be said, however, that it will best serve the community by acting in concert with the acute or short-stay medical services which are centred on the district general hospital. As has already been indicated, the services to be provided will be mainly medical, including the investigation and treatment of those short term illnesses which can be dealt with by a competent general

practitioner and which will often require reference to hospital mainly because they need nursing care in a hospital environment. This group of patients will include some who have been discharged by the specialist units of a district general hospital after investigation and treatment (including surgical) and have some need of continuing hospital care which could be provided by a general practitioner unit. We are still uncertain regarding the admission of patients suffering from psychotic illness to such units—much will depend on the attitudes of the general practitioners and their psychiatric specialist colleagues and on the staffing and accommodation provided. It should be emphasised that the general practitioner hospital unit must not be allowed to operate as a long stay unit although it will have a valuable part to play in supporting many families through medical emergencies which need temporary hospital care.

(iii) It is within this operational framework that we see the general practitioner making use of part of the hospital system for the benefit of the community which it serves. We believe that units of this kind can be effectively integrated into the service provided by district general hospitals, although we do not think they require resident junior medical staff. The general practitioner, either himself or operating through a rota with other general practitioners, will be responsible for any emergencies involving his patients and will only enlist the help of resident hospital staff in extreme emergency. The opportunity to take part in the care of patients in such units would be a valuable part of the experience of any young doctor engaged in a training programme for general practice. In the same way the unit would provide excellent opportunities for the training of undergraduates. This concept of the general practitioner hospital unit as having a training function carries with it the need to comply with the disciplines of record keeping, patient care evaluation, post-graduate education and participation in the affairs of the divisional system.

(iv) We have considered the effect which the establishment of general practitioner hospital units might have on the nursing and allied services. Clearly the quality of patient care will depend *inter alia* on the efficiency of co-operation between the various members of the team engaged in carrying out the treatment prescribed. While a considerable part of patient care can be carried out by nurses without reference to the doctor it is, nevertheless, beyond question that medical treatment must be prescribed by the doctor and dispensed, if not by him, by nurses and other colleagues. We are informed that in the one general practitioner unit in Scotland which is experimenting with the concept we propose, and which has been operating for nearly two years, little difficulty has been experienced in establishing effective co-operation between visiting general practitioners and their nursing colleagues in matters of patient care. Nevertheless it seems to us that the medical and other staff of a general practitioner unit will need to pay particular attention to the establishment of effective communications.

(v) In the earlier part of this section we argued the case for general practitioner hospital units in district general hospitals. We then considered whether the arrangements we propose would be appropriate in undergraduate teaching hospitals or in those hospitals which, although not primarily regarded as major teaching hospitals, house professorial units and play a large part in undergraduate teaching. Although undergraduate teaching hospitals have special responsibilities for teaching and research and for the support of regional or national centres for the more advanced and sophisticated clinical and other specialties they also have the responsibility for providing district hospital services in the area in which they are located. In this respect they are no different from district general hospitals in the smaller areas. It is our view that the operational differences between undergraduate teaching hospitals and district hospitals cannot justify a difference in attitude in relation to the needs of general practice. Indeed, we think that there will be particular merit in establishing general practitioner hospital units in teaching hospitals in view of the benefits which will be derived by all staff and students concerned from contact with such a unit in an atmosphere of education and study.

4.3 The General Practitioner Hospital

(i) While recognising the great benefit to rural communities which has accrued from the work of 'cottage hospitals' staffed by general practitioners, referred to as 'general practitioner hospitals' in this report, we would not wish to see this kind of provision extended to the large urban areas in the vicinity of district general (including teaching) hospitals. Although these general practitioner hospitals have operated successfully with the help of periodic visits by specialist colleagues from nearby district hospitals this arrangement has often been informal and personal and insufficient to overcome some degree of clinical isolation. It seems clear to us that the character of many of these general practitioner hospitals is changing because of an increasing and often well founded reluctance on the part of consultants to continue to provide specialist services remote from their operational base, and we recognise the case for withdrawing surgical and obstetric services from those peripheral units which do not have suitable continuing medical, nursing and other technical assistance, although we are aware of the public resistance which it often encounters. Nevertheless, we think that general practitioner hospitals still have a valuable contribution to make to health care, particularly in rural areas. We think that each such hospital should function as an integral part of the services provided by the district general hospital and that the staff should be represented within its divisional structure of medical organisation. This concept of a general practitioner hospital clearly involves the acceptance by the general practitioners staffing it, as in the general practitioner hospital unit, of the disciplines of record keeping, patient care evaluation and post-graduate education.

(ii) The supporting services required by the general practitioner hospital need not be elaborate, but it should have the technical resources necessary to meet most of its needs, and every effort should be made to avoid the transportation of patients over long distances to obtain technical services which could equally well be provided locally. Clearly the attachment of other health facilities such as health centres to the general practitioner hospital will improve the economic effectiveness of the support services provided by substantially increasing their utilisation. Facilities for simple diagnostic x-ray examination, electrocardiography and some tests of physiological function are essential and the unit should be supported by the specialist and technical resources of the district general hospital for their effective operation. While laboratory facilities provided at the general practitioner hospital should be simple they should be supplemented by the resources of the district laboratory services.

(iii) Having regard to the distribution of general practitioner hospitals in Scotland it seems to us that new hospitals of this kind should be established only if the alternative of providing a general practitioner hospital unit in the district general hospital serving the area is not feasible.

4.4 General Practitioner Beds in Specialist Units

Although we regard this proposition as the one least likely to be widely accepted and generally implemented it nevertheless offers opportunities for general practitioners and specialists to explore areas of collaboration between them which would improve the quality of patient care. The advantages of such an arrangement should not be under-estimated, particularly in general medical and geriatric units, and the experience gained should provide information on the optimum relationship between the general practitioners and the specialists. We consider that schemes of this kind could be put into operation with little difficulty and that the authorities responsible should set up pilot projects wherever opportunity presents.

Chapter 5 **The General Practitioner as a Member of the Specialist Team**

5.1 In the previous section (4.1 to 4.4) we considered how general practitioners could use the hospital for the care of their own patients. In this section we discuss their part-time participation in the work of hospital-based specialist teams. We believe that such participation will become a more generally adopted form of practice in the future as a means of satisfying the aspirations of suitably experienced young doctors who do not wish to commit themselves entirely to hospital or general medical practice in their traditional forms. We see this kind of arrangement as an opportunity for a general practitioner to profit by pursuing a professional interest as a member of a specialist team which will allow frequent and direct contact with colleagues engaged in a wide range of disciplines and participation in educational programmes. The concept of general professional training described by the Royal Commission on Medical Education (Cmnd. 3569, Chapter 3) would, if implemented, give a more broadly based clinical experience to many doctors, and would attract a number of young doctors to engage in the type of 'combined practice' which we envisage. Such an arrangement will also confer an advantage on the specialist teams because the family doctor with his primary base in the community will not only contribute to the staffing of the hospital service but will bring a breadth of experience which will enhance its work.

5.2 We have given a good deal of thought to the kind of training and qualifications required by general practitioners who wish to participate in the work of specialist teams. Although these doctors will practise in limited specialist fields and develop considerable expertise in their chosen disciplines we do not regard them as requiring the same level of training or performing the same functions as their full-time specialist colleagues. We see them primarily as general practitioners who, because of a special interest, have qualified themselves in some area of knowledge to an extent that they can make a contribution to the specialist team. They should complement the work of the specialist and they will require the level of training appropriate to their responsibilities but not to the advanced level of their specialist colleagues. In our view opportunities should be available for some of these doctors, if they so desire, to acquire specialist status by virtue of further training and the acquisition of acceptable qualifications.

5.3 The main advantage which will accrue to the community if the concept of 'combined practice' is widely applied will lie in the expertise

which will be carried by the general practitioners with a special interest to their work in primary care and will have particular relevance in health centre practice.

5.4 While the range of opportunity for this kind of participation is considerable the specialties which seem to be particularly appropriate to clinical integration are those in which the general practitioner is most frequently involved, namely internal medicine, obstetrics, child health, geriatrics and psychiatry. If a balanced family care system is to emerge in the future these specialties should be well represented in health centre or group practice. But the range of opportunity need not end there, and any form of 'combined practice' arrangement should be encouraged. There are already good examples in anaesthesics and accident services. We comment further on this below (paragraph 5.10–5.18).

5.5 In order to facilitate this kind of 'combined practice' arrangement some radical changes in general practice and hospital staffing structure will be needed to ensure the necessary redistribution of medical manpower and the establishment of new professional relationships. The successful conclusion of the current negotiations aimed at the creation of a hospital medical practitioner grade will go some way towards facilitating the kind of arrangement we have in mind.

5.6 It is also important that hospital-based specialists should participate in the work of health centres, which should play an integral part in the community specialist service.

5.7 Participation in 'combined practice' arrangements carries with it responsibilities as well as privileges. The doctor concerned will require to adapt his work to suit the requirements of both the specialist and the primary care team so that a continuous and efficient service can be provided for the community. While we believe that the amount of work involved in looking after the few patients he is likely to admit to hospital under his own responsibility could be absorbed without significantly increasing his work load, we think that participation in the work of a specialist team in hospital would require a significant part of his time if it is to be effective. To accommodate this increased load some compensating arrangements would be necessary in his general practice. Although much can be achieved by better organisation and by support from nursing and other colleagues it seems to us that some reduction in the size of his practice list will be inevitable.

5.8 It perhaps need not be stressed that general practitioners involved in this work must have had the training and experience for the job and the opportunity to enlarge their expertise by suitable post-graduate education. The present minimum post-graduate training for general practice recommended by the Royal College of General Practitioners includes three years experience in hospital and one year in general practice. Although the hospital training is widely based there is ample

scope for those with a particular interest to extend their experience before seeking entry to general practice. Although we are not generally in favour of proliferating post-graduate diplomas, we consider that some form of recognition should be given to doctors who acquire the additional experience and skill which is necessary to enable them to qualify for the kind of part-time post within a specialist unit which we envisage. The need for suitable training schemes for general practitioners and for the necessary recognition of those who complete them successfully should be brought to the attention of the bodies responsible for specialist professional training. This implies that the necessary posts will be available in the hospital service and that effective career guidance will be available to those who are seeking this kind of professional engagement. There is certainly considerable scope for bold experimentation in moving towards a new staffing structure of this kind. There is nothing in our proposals for the involvement of general practitioners in hospital which is contradicted by present manpower forecasts. Indeed, an improvement in the job satisfaction of general practitioners is central to the staffing of an integrated health service and opportunities must be opened up for young suitably trained general practitioners wishing to continue to work in hospital.

5.9 We have also considered the implications for the nursing service of introducing general practitioners as members of the specialist team in hospital and can identify no unsurmountable difficulties. Our nursing colleagues agree with us in this.

5.10 The dilemma of modern medical practice is how to apply the benefits of specialisation without neglecting the total medical psychological and social problems presented by the patient. This problem particularly applies to specialties in which the large number of patients embraced by the specialty exceeds the capacity of the specialist resources to provide adequate medical care by the criteria outlined above. The following paragraphs give some examples of the way in which general practitioners could contribute towards a solution of this problem and so bring the benefits of special expertise to a larger number of patients.

5.11 The Medical Unit. In its report on the *Doctors in an Integrated Health Service* (para 45) the Joint Working Party concluded that the general practitioner might assume some of the present responsibilities of the general physician to enable the latter to devote more time to the more sophisticated developments in medicine. We believe that these responsibilities will be exercised by the general practitioner when he admits to a general practitioner unit in hospital those of his patients for whom he is competent to provide satisfactory medical care with the resources available in that unit. In this section we are primarily concerned with the way in which the general practitioner can become an effective member of the specialist medical team. He may engage, for example, in the out-patient management of diabetes in the Endocrinology team, of hypertension in the Cardiology team or of epilepsy in the Neurology team. In these activities it is obvious how he could carry his expertise

into the community, *eg* health centre practice, in a way which would contribute both to the welfare of the patient and the development of the specialty.

5.12 The Psychiatric Unit. (i) The development of effective drug therapies and new methods of psychological and social treatments during the last two decades has changed the mental hospital from a closed institution, providing custodial care, to a centre from which treatment services are deployed in the community. Thus the hospital becomes merely one part of a spectrum of differing facilities which are organised to provide a comprehensive mental health service throughout the community. Such a service aims to make its impact at the point where the illness occurs and its success will depend to a large extent on the contribution of the general practitioner with his unique knowledge of family medicine and his own community.

(ii) At the present time psychiatric morbidity makes very substantial demands on a general practitioner, accounting for the second highest patient consulting rate, exceeded only by that for respiratory disorders. This load is created almost entirely by the neuroses which are largely family and social disorders. Working as a member of a psychiatric team comprising the social worker, nurse, clinical psychologist and hospital psychiatrist, the family doctor would not only enhance the quality of his primary care but also make an important contribution to the preventive aspects of psychological disorders.

(iii) The opportunity, therefore, exists for the general practitioner who can devote a substantial part of his time to the hospital service to acquire a considerable degree of specialist expertise, given the necessary training. Schemes already exist, notably in Livingston, where the family doctor receives training, including a University course, over a period of four years to increase his knowledge and broaden his skills in working in a multi-disciplinary team, before taking his place as a key member of an integrated service for the care of the mentally ill.

(iv) Not all general practitioners will wish or be able to make such a specialist contribution to a mental health service, but doctors providing two or three sessions per week have nevertheless an invaluable contribution to make in such facilities as day hospitals, sheltered homes and hostels and in the community services for geriatric psychiatry.

5.13 The Surgical Unit. Even within the general surgical service a general practitioner with suitable training and experience could probably make a significant contribution to patient care, not only by providing medical support for the surgical team but by participating in some of the operative procedures which do not require the expertise of the surgical specialist. This development would be particularly relevant in operative procedures such as haemorrhoidectomy, ligature or injection of varicose veins etc.

5.14 The Anaesthetics Unit. The general practitioner has frequently been engaged as a part-time anaesthetist in hospitals providing surgical services in both rural and urban communities. An extension of this arrangement for suitably qualified doctors in the larger centres of population would be of considerable benefit; and since posts in anaesthetics are readily organised on a sessional basis they are well suited to fit in with general practice.

5.15 The Paediatric Unit. We believe that the child health service of the future will have to be developed on a community basis and that general practitioners will require to make a significant contribution to its organisation and operation in the preventive, diagnostic and therapeutic fields. The role of the general practitioner, as the first point of contact for the family and as the physician most intimately concerned with screening services, should establish him in a vital position in the child health organisation for the district and some member(s) of every group practice should have a special responsibility for this work. The association with the child health team need not involve hospital duties—but where hospital participation can be arranged on the basis which we have suggested it should be encouraged. Nonetheless, all doctors belonging to the child health service should be in a position to have close and regular contact with colleagues in the same service.

5.16 The Geriatric Unit. A considerable amount of the time of the general practitioner is taken up in the care of elderly patients. While most of these patients will be treated at home or in a health centre many will require to be admitted to hospital where they will have the added distress of having to adapt to strange surroundings. This distress could be offset to a considerable degree if the patients remained under the care of the family doctor who is not only known to them but is in possession of information about their medical and social state which could have relevance to their diagnostic, therapeutic and social needs. As with the psychiatric service the general practitioner could play an important part in the activity of the day hospital as well as in the assessment and long-stay wards.

5.17 The Obstetric Unit. Although in future nearly all deliveries will take place in hospital it is important that the general practitioner should continue to play a vital role in what has been traditionally recognised as an essential aspect of good family practice. As the doctor of first contact, the general practitioner should clearly share the ante-natal care, with the contribution of the specialist team (possibly including a colleague in the group who has a part-time specialist contract in the obstetric unit) being either at hospital, clinic or health centre. Facilities however, in close association with or as part of specialist units should still be provided for the adequately trained practitioner who wishes to confine his own selected patients or those of other practitioners within his group. Such practitioners could also serve on a sessional basis with the specialist team.

5.18 Accident and Emergency Services. The employment of general practitioners on a sessional basis in a number of accident and emergency units has proved a success, and there are good opportunities for extending such arrangements to doctors with suitable training and experience. During recent years there has been an increasing trend towards development of deputising services to cover the unexpected medical need of the community. Many general practitioners participate in these services while others contract with them to provide the out of hours requirements of their registered patients. Along with this development there has been an increasing use of the hospital accident and emergency departments by patients who should, properly, have consulted their own doctors. Having regard to these trends it seems logical to us that thought should be given to the concept of accommodating all out of hours casual services in the local hospital or health centre, whichever happens to be appropriate and convenient. In our view these services should be operated by general practitioners on a rota basis within their contract of service.

Chapter 6 **Education and Training**

6.1 Most medical teaching takes place in hospital and is undertaken by hospital staff so that many undergraduates tend to see hospitals as the sole source of medical knowledge and experience. It is desirable that the undergraduate curriculum should include a course on the clinical problems found in general practice. Many medical students would benefit from some exposure to general practice and the experience of family doctors. The general practitioner has an important role as a teacher, not only of undergraduates but also of trainees in general practice. While his help in teaching in the specialist wards of a hospital is acknowledged, the main contribution will be in the general practitioner units, in health centres or in group practice. Departments of General Practice should be given opportunities to take part in teaching students and in organising participation in continuing and combined medical care between hospital, general practice and social work departments. The similarities and not the differences between hospital and general practice problems should be emphasised.

6.2 The Royal Commission on Medical Education (Cmnd. 3569, para 59) concluded that a period of general professional training is an essential part of the preparation of the young doctor for his future career as a general practitioner or specialist (including community medicine). It was envisaged that a further period of professional training would be necessary in the chosen specialty (including general practice).

6.3 If these arrangements become generally accepted a general practitioner who opts to take part in an additional specialty as a member of a specialist team, should, if the standards of the service are to be improved, have additional training and experience (see para 5.2).

6.4 In view of the rapid changes taking place in medicine it is important that the general practitioner should be regularly informed by means of refresher courses of recent advances over a wide range of subjects. The recent increase in opportunity to attend refresher courses is welcome and should continue throughout a doctor's career, but another valuable means of keeping in touch with advances is regular contact with his colleagues, both general and specialist, in the Postgraduate Medical Centre.

6.5 The Postgraduate Centre provides, within reasonable distance of every practising doctor, an opportunity to meet his colleagues in other fields of medical work, as well as to gain access to a library and to attend

lectures and seminars. It forms the educational focus for a wide variety of activities arranged for all doctors within the locality, although these activities may not necessarily take place within the confines of the Centre itself. It will complement and not replace those postgraduate activities already provided by Universities, Royal Colleges and other professional bodies, and we strongly support the rapid development of such Centres in Scotland. They will do much to bring together those in various branches of medical practice and by promoting free discussion and exchange of ideas, maintain the high standard of professional work expected of Scottish medicine.

Chapter 7 **Conclusions**

7.1 Having reviewed the problems we have concluded that there is a strong case for improving the opportunities for general practitioners to participate more fully and effectively in hospital work. While we believe that the kind of participation we have in mind will gain pace with the recruitment of young doctors who will increasingly expect to be able to maintain their association with the hospital, we are satisfied that an immediate start should be made to provide facilities in hospital which will allow general practitioners to be responsible for the care of some of their patients and to extend participation in the work of specialist teams in hospital.

7.2 We are very well aware of the difficulties which have to be resolved before all our objectives are achieved, but none of these is sufficient to prevent a start being made to achieve the form of integration which is the subject of our remit in a considerable and expanding number of centres. We believe that amongst these difficulties the traditional attitude of the doctors concerned is an important factor, and we hope that the considerations we have set out in this report will be sufficient to encourage a substantial and effective measure of co-operation.

7.3 We believe these proposals should be pursued with vigour by all those concerned if the developments we envisage are to be achieved within an acceptable time scale.

7.4 In order to reach the objectives which our report outlines we think that certain practical steps should be taken, as follows:

7.4.1 A number of general practitioner hospital units comprising blocks of beds for which the general practitioner has full clinical responsibility should be set up in district general hospitals and in teaching hospitals. Regional Hospital Boards should be asked to give urgent attention to the implementation of this recommendation bearing in mind that radical changes of the type proposed require bold experimentation and evaluation. Responsible professional organisations including the Royal Colleges and the Royal College of Nursing should consider how the development could be encouraged.

7.4.2 General practitioner hospital staff should be assimilated into any medical staff organisation which exists or is developed in the future in the district general hospitals and we recommend that the appropriate steps should be taken to achieve this as an effective means of clinical integration.

7.4.3 Pilot schemes should be set up by Regional Hospital Boards to investigate the feasibility of general practitioners being responsible for their own patients in specialist units, *eg* internal medicine, psychiatry, geriatrics, paediatrics etc.

7.4.4 Various forms of 'combined practice' arrangements both inside and outside hospital should be developed and Regional Hospital Boards should consider ways of extending this type of medical practice within its existing staffing structure.

7.4.5. We recommend that the Joint Committee for Higher Medical Training, the Scottish Council for Postgraduate Medical Education, the Royal Colleges and other bodies with responsibility for training should be invited to consider what courses of training could be set up for general practitioners undertaking hospital work.

Acknowledgment

In conclusion we wish to express our sincere thanks to the Secretariat. We are particularly indebted to Dr John Baldwin, our Medical Secretary, for the efficient manner in which he handled the various stages of the report.

J. Crooks (*Chairman*)
A. G. Donald
A. H. Duncan
J. Knox
K. G. Lowe
E. M. McGirr
I. M. Macgregor
J. Mackay
T. C. K. Marr
J. B. Rae
A. G. Reid
I. M. Richardson
G. B. Shaw
F. I. Stewart
J. D. Thomson
P. A. P. Mackenzie

Dr J. T. Baldwin (*Medical Secretary*)

Printed in Scotland for Her Majesty's Stationery Office
by Howie & Seath Ltd., Edinburgh. Dd. 952813 K 104

Her Majesty's Stationery Office

Government Bookshops

13a Castle Street, Edinburgh EH2 3AR
49 High Holborn, London WC1V 6HB
109 St Mary Street, Cardiff CF1 1JW
Brazennose Street, Manchester M60 8AS
50 Fairfax Street, Bristol BS1 3DE
258 Broad Street, Birmingham B1 2HE
80 Chichester Street, Belfast BT1 4JY

Government publications are also available through booksellers

SBN 11 490892 3